

Dr. Patrick Anderson

Center for Gynecologic Oncology
& Women's Health

Permission for Patient Contact

(Effective April 14, 2003 under Federal Law)

Contact Information: This information will allow this office to contact you with appointment reminders or other information relevant to billing or treatment.

Please fill out the bottom portion in its entirety.

Please list two phone numbers that we may use to contact you:

1. Phone #: _____ 2. Phone #: _____

In the event that Dr. Anderson or his associates are unable to reach you concerning your status with this office (i.e. appointment, test result, billing statements, etc.) may we leave a message on your:

Home answering machine Yes _____ No _____
Cellular voice mail Yes _____ No _____
Work voice mail Yes _____ No _____

If we need to contact you at work and you are unavailable, may we leave a message with the receptionist for a call back to our office? Yes _____ No _____

Authorized Representatives: Please list the names of any person or persons that may be involved in your treatment that we may be permitted to discuss anything concerning your medical status (i.e. practitioner, parent, spouse, sibling etc..). Please note, if a name is not listed, we are required by law to protect your information and we will not discuss anything pertaining to your healthcare with that unlisted person.

Name: _____ Name: _____

Address: _____ Address: _____

Phone #: _____ Phone#: _____

Patient Name: _____ Date: ____/____/____

Signature: _____ Relationship: _____

(Parent or Guardian if patient is under 18yrs old)

****Please note that the law requires a written notice for any changes or additions to the information that you have listed above. Any verbal communication of changes or additions will not be honored by our office.**

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South Orange NJ 07079

Phone: 973 762-7270
Fax: 973 762-1980

Email: gyncenter@optimum.net